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ORIGINAL ARTICLES.

Report of a Case of Benign Tumor of Larynx, with Specimen.

By HAL FOSTER, A.B., M.D., Kansas City, Mo.

Written for the Kansas Medical Society meeting at Atchison, May 3, 4 and 5, 1894.

Mr. President and Gentlemen of the Kansas State Medical Society: The following case is reported because of the unusual interest attached to it. The literature on this subject is very extensive, and no doubt perfectly familiar to each one of you. I will not give any statistics in this short paper, but will confine my remarks strictly to this case.

Mrs. S., age 35, German, wife of a well-to-do farmer near Shelby, Mo., was brought to my office October 13, 1891, by Professor Wainright, of Kansas City. The family history of this patient is one of unusual interest, as you will see. Mother and father both living and well. About two years ago a sister was operated on in St. Louis for ovariectomy. Another sister had a small tumor removed from the side of the head near the ear. Dr. Wainright removed a tumor about as large as a marble from the great toe of this lady's only brother. I had the pleasure to examine the toe and to see the tumor after its removal. My patient, the only remaining member of the family, had this tumor in her larynx. This lady was very thin, some difficulty in breathing, voice had been entirely gone for a year. She was very much alarmed and exceedingly anxious about her condition. The vocal state was one of complete aphonia. I

called a number of physicians to see and examine this case—Drs. Bond, Greene, Hardin, and Morrow. No pain was experienced; it required great effort at every attempt to speak. In the presence of the family and my friend, Dr. Wainright, a ten per cent. solution of cocaine was applied with sprays and cotton on applicators, and by means of Schroeter's laryngeal forceps, this specimen was removed from the side of the left vocal cord. There was absolutely no shock, and only a few drops of blood. She began to speak the same afternoon and has continued to talk since.

Her voice is natural and strong.

I gave her 1-60 gr. strychnia morning and evening, and applied uninterrupted current not exceeding 3 or 4 milliamperes by means of moistened sponge electrodes to outside of throat for a week, after which time any treatment was unnecessary, because her voice was entirely restored. This lady was in Kansas City October, 1893, to witness the Priests of Pallas parade. I examined her throat and found it to be perfectly normal. She wrote in January of this year stating that she had no difficulty whatever.

The base of this growth was cauterized with galvano cautery lightly.

The treatment of these growths consists in removing them by chemical and mechanical methods. The chemical method is accompanied with more or less danger. It is true that trichloroacetic or chromic acids may be used by first being fused on applicators, which prevents spreading.

The surgical or mechanical method is accompanied with so very little danger that it should always be first resorted to in every case.

This method is done by means of laryngeal forceps. Their number is legion—nearly every laryngologist has a long or

short forceps. Among the number are McKenzie, Knight, Bosworth, Cass and Schroeter. In my hands the Schroeter instrument has been the simplest and best means at my disposal.

Snares can be used to great advantage in a few cases. Their use, however, requires much more care and skill on the part of the operator.

In removing a tumor of the larynx it makes very little difference what method the operator uses. The restoration of the voice is the object in view.

On the day of the operation the patient should partake of a very light breakfast. Gagging is not near so annoying and it takes much less cocaine, and the after effects are much better.

When patients are troubled with hoarseness or loss of voice on the slightest provocation, the larynx should be carefully examined to ascertain if it is free from laryngeal growths.

Hemorrhage from Vaginal Tumor.

By F. O. BRAINERD, M.D., Oakley, Kas.

On the 16th day of last July I was called in haste to see a lady living about 18 miles from my office, the messenger stating that said lady was flowing profusely from the womb, and had been so doing for a number of hours before he was sent after me. I drove with all due haste to Mr. M's place. It being so dreadful hot I was sometime getting there. On arriving I found the lady almost lifeless from loss of blood, she had at that time been flowing some eight or ten hours. She was not pregnant, and could therefore give me no reason for the cause of so great an hemorrhage. I tamponed her vagina, removing before I did so, some large clots of blood. In my hurry to stop the flow of blood I did not make an examination of os uteri. After thoroughly packing the vagina with cotton tampons the flow ceased. I then gave her stimulants and restoratives, and had the satisfaction in

about an hour and a half to see her improving fast, and before leaving her to return home she was almost herself again, her temperature was normal, pulse 90, respiration 20. I left her some tr. ferri chloridi, to be given in 30-drop doses every 20 minutes should she again commence to flow. Also left her a few powders of 6-grain doses of chloralamid to procure sleep, as she had been very wakeful for the past week or ten days before this hemorrhage occurred. I then left her, telling them I should drive out again the next day and remove the vaginal packing. I saw her again the next day. Found her up and about the house feeling somewhat weakened, but aside from this was quite well. Had slept well, and had no signs of returning hemorrhage; had taken no iron, and but two of my chloralamid powders, which she said put her to sleep shortly after taking the second one, and she knew no more till morning. I then began to remove the packing very carefully at first, but as I could observe no signs of hemorrhage I took it away as fast as I could. After removing it all I made a specular examination, and to my surprise I found a very small tumor adhering to the anterior lip of the mouth of the womb. It seemed to be very firmly attached to the under side of anterior lip of womb, and as far as I could judge from a digital and specular examination it was simply a small cyst. Now the reason why I have reported this case is because this patient not only did not know of there being a tumor there or elsewhere, never had felt anything there, nor had she ever had any pain or hemorrhages from the uterus. She being a married lady of about 16 years, never had borne any children, and in fact was, up to the date of her hemorrhage, and always had been, perfectly healthy. I explained to both she and her husband what I had found, and advised its removal. They wished to wait further developments and nothing has occurred since. I have reported the case exactly as it was. What caused the hemorrhage? and why did not the lady discover the tumor? how long has it been there, and has it been the cause of sterility? These questions I should be

greatly pleased to have answered by some of the JOURNAL'S subscribers. I have been in practice for a good many years, but it is ahead of me. The tumor is the size of a large hickory nut, dull, dusky red on first appearance, but soon becomes a light fiery red in color on manipulation. No fluctuation and no sign of rupture.

Money In It.

Editor Kansas Medical Journal.

I report this case because it is out of the regular routine of ailments which in every day practice we are called upon to relieve.

Mr. P. G. M——, of Effingham, Kas., came to my office June 9, 1894, stating that he felt languid and nervous, could not work as he used to, appetite poor, did not sleep well, bowels irregular, and after each stool there was a large amount of mucous discharged, yet no griping. There was a constant heavy ache in right side, I found a general dullness in right lung, with obstruction in right bronchus. At this point Mr. M—— told me he had a dime in his lungs, that on the second day of last February, while holding a ten-cent piece in his mouth it accidentally slipped into his windpipe and nearly choked him to death, and that it was still there. I suggested that he might be mistaken and that instead of going into his lungs he had swallowed it. But my patient said he had studied the silver question thoroughly, and knew exactly what he was talking about. I put him on a good constitutional treatment, and also advised him to stand erect, with shoulders thrown back, and slowly inhale all the lungs would stand and then forcibly throw the air from his lungs; this do morning and evening. Patient followed instructions and yesterday morning for the first time was taken with a violent fit of coughing and the aforesaid dime was ejected from its lodging place, and I now have it in my possession. Patient is quite well and happy.

C. H. GILLMAN, M.D.
VALLEY FALLS, KAS., Aug. 13, '94.

The Treatment of Jaundice.

New York Medical Record.

Dr. M. Alivia, of Viterbo, read a paper before the International Congress on this subject, of which the following were the conclusions:

1. Long-continued biliary stasis, comprising the secreting cells of the parenchyma of the liver and producing a certain anemia of the organ, markedly reduces, and sometimes suppresses, the secretion of the biliary acids. The gravity of the phenomena described under the name of biliary intoxication, does not therefore depend upon the action of these acids.
2. The scarcity or absence of bile in the intestinal canal modifies very seriously the chemical processes there taking place.
3. One of the most common of the gastric changes in icterus is the suppression of hydrochloric acid secretion.
4. There is little or no loss of carbonate of sodium in these cases.
5. The reaction of the contents of the stomach is usually alkaline, less often neutral or faintly acid.
6. The physiological activity of the bile and of the pancreatic juice in the intestine is retarded.
7. The chlorides in the urine are increased, the reaction of the fluid is often alkaline, there is diminution of urea with an abundance of products of the aromatic series.
8. The more marked are these characters so much the more grave are the disease and its clinical manifestations.
9. Alkaline treatment does not modify these conditions. The effect of the acid treatment is, however, to diminish the chlorides, to restore the normal activity of urinary reaction, to increase the excretion of urea, and to reduce that of the aromatic products. At the same time there is a progressive increase in the weight of the body.

ONE drop of tincture of aconite in water will often control vomiting.

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Topeka, Kansas, Saturday, Aug. 25, 1894.

The Asthmatic Nose.

The exaggerated ideas of the importance of nasal reflexes as formerly held by many specialists, have led the more conservative general practitioner to doubt the existence of any relation between the nose and any pronounced disturbance of function in other parts of the body. The part played by the nose in the various forms of asthma has been so clearly demonstrated by some of our ablest authors that no reasonable excuse can now be given for neglecting a careful examination in these cases.

Many theories have been advanced as to how the disturbance is produced and as to just what pathological condition in the nose is necessary to produce it.

Where there is sufficient hypertrophied tissue to produce pressure upon the septum,

or, on the other hand, where the septum deviates sufficiently to impinge upon the turbinates, we are most likely to have some reflex disturbance which may manifest itself in an attack of asthma, or an irritability of the larynx. That there are other causes for asthma it is impossible to deny, but that there always exists a certain well defined relation between nasal disease and what is commonly called hay fever is just as certain. From the experience we have had with these cases we are inclined to believe that the middle turbinate is the *sine qua non* in the production of this disease. In all the cases we have seen there has been marked disturbance in the region of this body with pressure caused either by hypertrophied tissue or an enlargement of the bone. Just how this pressure causes a disturbance in the respiratory function, and why it should be perennial in its occurrence, are questions of much uncertainty. Pollen of the different Autumn plants and dust are regarded as very doubtful factors in bringing on the attack by some of our most eminent observers. The peculiarity of a regular recurrence at almost exactly the same time each year suggests the probability of some mental influence. However this may be, slight operations in the nose previous to the expected attack often delays or entirely prevents its occurrence.

Where polypi or other growths exist their removal often results in permanent benefit. The success which has attended careful nasal treatment in asthmatic cases seems at least to promise a better understanding, and a more scientific management of such cases.

During an attack of hay fever frequently repeated and prolonged douching with hot water gives most satisfactory relief. The oedema seems to disappear and then follows a most agreeable sense of comfort. Cocaine produces temporary relief, but the secondary effect is really to increase the oedema. Weak solutions of atropine sprayed into the nose will often relieve the local symptoms. Local treatment alone is not usually sufficient in these cases. Some attention must be given to the general condition of the patient.

The syr. of hydriodic acid has been highly recommended, and we have found it very satisfactory in these cases. Strychnia in 1-30 gr. doses is also a valuable adjunct to the local treatment.

The People vs. Sanitation.

The popular prejudice against all legal enforcement of cleanliness is doubtless more due to the lack of knowledge than carelessness. The popular idea of cleanliness and the medical comprehension of the term, are quite different. The present opposition to any expenditure of the public funds for sanitary purposes is doubtless due to the impression that because there is little sickness in the State it therefore must be in good sanitary condition. A full realization of the error of such reasoning will come most forcibly when it is too late to repair the damage. The piles of manure and other filth which, on account of our exceedingly dry weather, are causing no unpleasantness, will when once soaked with a few good rains and exposed to the sun soon give evidence of their noxious qualities. If our own city is a fair sample of the sanitary condition of the State we might well pray for a flood. It seems difficult to feel the dangers of an epidemic until it is upon us. Cholera in St. Petersburg does not alarm us, and cholera in New York only makes us feel sorry for the unhealthy condition of that unfortunate city. The wonderful confidence we have in our own perfect (?) sanitary condition is appalling to those who have occasion to investigate. We have had no epidemic of cholera, but every Fall for at least the past six years we have had a sufficient number of cases of diphtheria and scarlet fever to approach very nearly an epidemic. When such things occur in Chicago we most readily ascribe it to the well-advertised filth of that city. The cause is doubtless the same wherever these diseases occur, and to preserve the boasted health of the community it might be well to begin an early investigation of the causes of the regular recur-

rence of these afflictions. We have previously called attention to the condition of some of our public grounds. Other sources of infection may exist, but it seems gross negligence to allow those which are so apparent to remain. Sanitary laws have been formulated and sanitary officers appointed to protect the people from the scourge of infectious diseases, yet the strongest opposition to the enforcement of such laws comes from the people they were intended to protect.

Dysentery.

Dysentery in the pre-sanitary times was a disease of frequent occurrence, but since the establishment of sanitary boards throughout the country the disease is comparatively rare. Dysentery was formerly attributed to malaria, and was most severe in low and filthy localities. It existed in every known country of the world. The symptoms were uniformly the same except in their being mild in some cases and severe in others. There is more or less griping with frequent mucous discharges from the colon, which become mixed with blood. The glands situated in the large bowel are the seat of the inflammation. The function of the liver is disturbed and its secretion altered. The cause of the disease is usually a germ, though it has not yet been identified and classified. The pathology and symptoms indicate a specific causative agent. The duration of the disease is from one to two weeks. The best treatment is the removal of all morbid material from the bowel by large doses of sulphate of magnesia. This may be followed by opium and bismuth.

In old people there is danger of collapse, and it may be well to substitute castor oil for the magnesia. Under our present sanitary regulations dysentery should be relegated to the past.

TRICHLORACETIC acid applied locally to the bleeding point, will usually check nasal hemorrhages.

Medicine Among the Aztecs.

Journal American Medical Association.

In a review of Flores' "History of Medicine in Mexico," Dr. David Cerna, of the Medical Department of the University of Texas, furnishes (*University Medical Magazine*, July, August, 1892; *Tri-State Medical Journal*, May, June, 1894,) some interesting information concerning medical education and the regulations of medical practice among the Aztecs during the earliest period of ancient Mexican history, *i. e.*, that prior to 1521. The scientific professions were considered sacred; the privilege of following them was tendered only to the higher classes of society, and such professions were studied under the guidance and immediate supervision of the priests, who, among the Aztecs, were the most learned. The teaching of medical science, however, was both sacerdotal and hereditary, and father-physicians usually made physicians of their children, and guided these afterwards in the practice of the healing art. For the proper study of the more or less rudimentary medical science among the Aztecs, the branches required to be mastered were medical and surgical pathology, therapeutics, botany, pharmacy, and lastly, clinical medicine and surgery. The studies of the pharmacist were more simple, but he was required to possess a knowledge of botany and pharmacy. Obstetrics remained always in the hands of women, and of those females especially who had already borne children, and had, therefore, some practical knowledge. These, stated in a few words, were the principal branches of the healing art taught to those who intended to follow the profession of physician, surgeon, midwife, and pharmacist. The candidates, however, who had satisfactorily finished their respective studies, were not allowed to go into practice without legal authorization. Physicians, surgeons, obstetricians and pharmacists, even after graduation, were obliged to obtain licenses before they were permitted to practice, and, notwithstanding the preva-

lence of superstitious ideas, quackery and witchcraft in connection with medicine, were severely punished by a special court or tribunal. Transgressors of the law, in this respect, frequently fell victims to human sacrifice so common among the Aztecs. Physicians were not idle in regard to medical studies; they had their societies which provoked reunions especially at the capital of the empire, and in them the most interesting medical topics were brought forward and discussed. They were diffused throughout the land, especially at the two great cities of Texcoco and Tenochtitlan, civil and military hospitals for the reception of the sick among the poor and destitute, and of those who had been injured in the service of the country. The hospitals were superintended by the ablest physicians and surgeons, although always under governmental control. Five hundred years before the American Public Health Association met beneath the shadow of the great bust of the last Emperor of the Aztecs, that picturesque and interesting people had already attained a remarkable degree of development in the most complex of the learned professions—that of medicine.

Treatment of the Summer Complaint.

William F. Waugh, A.M., M.D., in *The Chicago Medical Recorder*.

I have ventured to bring the subject of summer complaint before you, because of its prevalence at this season, the enormous mortality it causes, and because I believe that many of these lives might be saved by the treatment I had the honor to introduce, and by the application of the principles of good hygiene. The latter should rather be first mentioned, as bad domestic hygiene is largely responsible for the disease and its fatality. In studying the causation of malignancy, I have been struck with its invariable connection with bad hygiene.

During my last service as sanitary inspector more than one thousand cases of infectious disease came under my notice. Of these, there was none that presented malig-

nancy, or even marked severity, that was not associated with palpable defects in the hygienic condition of the premises; such as foul, leaky, or overflowing cesspools, or masses of decomposing filth in the rooms, cellars, yards, alleys, or gutters. The same thing is true as to summer complaint; and much of the benefit derived from taking children to the parks, or on the water, is really due to getting them away from their unhealthy homes.

As heat is one of the direct etiological factors of summer complaint, a leading indication is to keep the sufferer cool. The room should be darkened during the heat of the day, and is best cooled by placing large blocks of ice in it. A tub of water should be kept standing in the room, and the child allowed to bathe at will, the clothing being such as may be readily laid aside for this purpose.

The diet must be regulated scrupulously. It did not require Vaughan's great discovery to teach clinicians the dangers of milk. From its source until it reaches the consumer, milk is of all foods the most prone to acquire toxic properties; from the cow, or her surroundings, from adulteration, from accidental contamination, from dirty or unskillful handling, or from spontaneous decomposition. Except under ideal conditions of supply, I exclude milk from the diet of children with summer complaint. When given it is best in the form of junket, or peptonized, as the secretion of the digestive ferments is more or less suspended during the attack.

The best food for very sick children is the raw white of egg, dissolved in ice water. No other food can be retained if this is rejected; and no other will be so quickly absorbed and assimilated as this alone of all foods is directly absorbed by the growing chick without passing through a digestive system. Other foods suitable are bovine, Carnrick's and other predigested foods, raw beef—ice cold, or warmed through—rice, dry toast, or zwieback, coffee, and distilled water. Food should be given in small quantities, with full doses of the digestant principles, at intervals of not less than two

hours. If the stomach be too irritable it should have several hours rest; food being given by the rectum, and the body rubbed with warm oil several times a day. Water should be given freely; but if the child be sweating profusely, and drinking incessantly, the perspiration should be checked by agaricin or camphoric acid, and drinks only allowed at stated intervals.

In the simplest form of the disease, summer diarrhea, we have loose fetid stools, flatulence, abdominal pain and tenderness, anorexia, and the child becomes thinner. The indications are to clear the bowels of offensive matter and re-establish healthy secretions. For this there is nothing better than the neutralizing cordial of

R

Vin. ipecacuanhæ..... ʒj
Potass carbonat..... ʒss
Tinct. hydrastis..... ʒiv
Syr. rhei aromat. q. s. ad... ʒiv

M.

S.—ʒss to ʒij every four hours.

If the stools are white and pasty, I prefer to give calomel, gr. 1-10, with a grain or two of prepared oyster shell, every four hours. This simple treatment, with attention to the diet and hygiene, is usually sufficient, and is preferable to the use of astringents.

In graver cases, we may have the symptoms of an acute catarrhal gastritis, with incessant vomiting, gastric pain, great thirst, and little or no diarrhea. The indication is to subdue the irritability of the stomach, and check any fermentation or microbic action in this viscus. For this I give the sulphocarbolate of zinc, gr. ss to ij, every one-half to two hours, with several grains of bismuth subnitrate.

If the force of the disease be exerted on the intestines, we have symptoms of enterocolitis; frequent, watery stools, with abdominal pain and tenderness, rapid emaciation, and fever. The same treatment is indicated, with hot fomentations to the abdomen, and all starchy food forbidden. Should the fever not subside speedily, a few grains of phenacetine or granules of aconitine may be given. If the rectum be mainly affected and the

symptoms assume the dysenteric type, the sulphocarbolate is still to be given, with very small doses of Dover's powder to check peristalsis, and small enemas of hot water, one-eighth grain silver nitrate or five grains of the sulphocarbolate to the ounce.

In the cases properly called cholera infantum we have the choleraic group of symptoms, rice water evacuations from the stomach and bowels incessantly recurring, rapid emaciation, feeble or imperceptible pulse, cold extremities, muscular cramps. For this condition no remedy equals the sulphocarbolate, in doses of one-half to two grains, every half hour. The normal salt solution injected hypodermically, relieves the cramps and restores the circulation. Pellets of ice, and small doses of brandy, should be given frequently.

Cases of heat exhaustion, and of true sun-stroke, occur frequently in connection with summer diarrhoea, demanding stimulants and heart tonics on the one hand, antipyretics and cold on the other.

There remains a condition of the greatest interest, that formerly denominated hydrocephaloid. In this we have a characteristic group of symptoms. The pulse is small and tense; the pupils contracted, the stomach intolerant, but the diarrhoea may be suppressed. The temperature is 103° to 104° F. The epigastrium and forehead are burning hot, the extremities cold. If old enough, the child complains of headache, or is delirious or comatose. The condition is one of debility approaching collapse, and is apt to be fatal unless antiseptic treatment is instituted. It is especially likely to appear when opium has been given injudiciously, but may occur when no opiate has been administered. My attention was first attracted to this condition by the similarity of the group of symptoms to those presented in diphtheria when the nasal tract has been invaded. In this case, the same symptoms present themselves except the epigastric burning. I had learned to recognize in the diphtheritic disease a sapremia, due to the absorption of toxins generated in the nasal passages, and relieved by clearing them out with antiseptic lotions. This led me to the

use of antiseptics in the so-called hydrocephaloid, with the happiest results. Under the use of antiseptics, the temperature falls, and all the symptoms subside with a rapidity I have never witnessed under the use of any remedy except the sulphocarbolate. From its success here I was encouraged to employ this agent in all forms of the summer complaint, believing that all are due to the operations of microorganisms in the alimentary canal. During the past seven years, since I adopted the use of this salt, and recognized the necessity of obtaining it in a state of chemical purity, I have had no deaths in private or consultation practice from any form of summer complaint.

Since 1884 I have been urging upon the profession the importance of intestinal antiseptics; and from many correspondents and former students I have the cheering reports of results as good as my own.

In the June number of the *Alkaloidal Clinic*, Prof. Shaller, of Cincinnati, states that the zinc sulphocarbolate has won his utmost confidence after a very extended experience in septic conditions of the alimentary canal. He gives a granule of one-sixth grain every half hour to a child one month old. In many other affections the principle of intestinal antiseptics is being applied. The following is a summary of a leading article on this subject in the *British Medical Journal*, in which the matter is covered admirably.

"Gautier proposed the name of leucomaines for the alkaloids elaborated in the living body by simple putrefaction of the intestinal contents. Of these, indol, skatol, and phenol are toxic and antiseptic. Their amount in the urine exactly represents the amount of intestinal putrefaction. Besides these, some pathological microorganisms can only produce their toxins in the presence of those of putrefaction. Bocklisch has shown that this is the case with the bacteria of cholera morbus. In any case, the following symptoms call for the use of intestinal antiseptics: Diarrhoea, excessively fetid stools, flatulence, abdominal pain, tenderness and distension, and to these may be added headache, delirium, aching bones, in-

somnia, and ataxic depression, symptoms due to the entrance of toxins from the alimentary canal into the blood."

In typhoid fever my success with the sulphocarbolates has been paralleled by many others, with salol, beta-naphthol, resorcin, betol, and recently with the new bismuth compounds, such as beta-naphthol bismuth. As in all continued fevers the secretion of the natural antiseptics, the bile, etc., is in part or wholly suspended, the use of these agents is indicated. I am not, therefore, surprised to hear of their successful use in pneumonia and scarlatina, and will venture the surmise that in all continued fevers securing internal antisepsis will result in a marked reduction in the number and gravity of the symptoms, by the elimination of all depending on the absorption of toxins from the alimentary canal.

In anemia, chlorosis, malnutrition, headache, irritable stomach, melancholia, and other nervous affections, great benefit has followed the use of these antiseptics.

When enteritis is due to putrid food, they are specifics.

Dr. William Hunter urges intestinal antisepsis for pernicious anemia.

Tuberculous enteritis has been benefited by guaiacol.

It is now claimed that other diseases are really caused by the absorption of toxins from the alimentary canal; and among these some writers place uremia, diabetes, some spinal affections and rheumatic fever. As to the last, it may be noted that our best rheumatic remedies are all intestinal antiseptics, the salicyl group, resorcin, and acetanilid.

It is surely evident from this representation that the reproach on the modern germ theory, that it has not added materially to our therapeutic resources, cannot be admitted as regards diseases of the intestinal canal. The principle is full of promise for the future.

DR. PADDOCK, of Netawaka, one of the landmarks in Kansas, died last week of a malignant growth in the stomach.

Day and Night Urine.

Quincke (Int. Klin. Rundsch., No. 47, 1894).—American Medical-Surgical Bulletin.

It is a well known fact that the urine secreted during the day is generally more abundant, lighter in color, and more fluid than night urine. This variation is, first of all, due to the difference in the amount of fluid supplied to the organism. That various positions of the body and sleep play a certain role has already been determined by a number of observers. The author found that, while in reclining positions of the body, the urinary secretion is augmented, it is diminished by sleep and the abstraction of water from the body at night in the absence of compensatory supply. The last two moments generally predominate so that the urinary secretion at night (reckoned hourly) is usually less (and the urine more concentrated) than during the day. The author sought to determine if, and how far, this usually accepted relation between day and night urine was altered by pathological conditions.

Examination of heart and renal cases gave the following: At night a more abundant urinary secretion was present, not only in the sense that at night the hourly secretion was less far than normally behind that of the day, but very often it exceeded the latter, day and night being in proportion as two to three and more. This excess of the nocturnal secretion occurred not only in patients who left their beds during the day and, perhaps, in this manner acquired an oedematous condition of the lower portions of the body, but it likewise took place in those patients constantly confined to bed. This result the author suspected from the beginning. It appeared probable to him that in such persons, who on standing or walking acquired oedema of the feet, the quantities of water deposited during the day, if they enter the circulation during the night along with the disappearing oedema, wholly or partially pass over into the urine—that the physiological relation between diurnal and nocturnal urine is altered or

even reversed. In renal cases the nocturnal polyuria manifested itself in about the same manner and degree as in heart cases. In prostatic patients a decided, in part enormous, excess of the night urinary secretion over that of the day was noticed. The author also examined other patients (carcinoma ventriculi, diabetes insipidus) and determined that the intensity of the urinary excretion in solid matters as well as in water, is greater in the night than during the day. These researches have shown that the relation of the urinary secretion at night to that of the day is, in many patients, decidedly different from the condition in the healthy. While in the latter the hourly secretion by day and at night is about 100:25 to 100:60, in the sick the nocturnal urinary secretion is more or less augmented, so that the relation may become 100:100 to 150, or even 100:200. In the healthy, as well as in the sick, rising and exercise during the day appear to elevate the nocturnal secretion, or, in other words, to shift the secretion of the day to the night. But the influence of rising or "lying a-bed" is subordinate and not always recognizable. The transference of the secretion from the day to the night is just as pronounced in those confined to bed.

The author concludes that the cause of this nocturnal polyuria is to be sought in sleep, in the external rest, and in the elimination of the numerous external exciting factors.

The Best Treatment of Hemorrhoids.

Therapeutic Gazette.

Stevens contributes a paper on this subject to the *Cincinnati Lancet and Clinic* for May 12, 1894. He thinks that internal hemorrhoidal tumors are best treated by direct removal. There are several methods proposed for the accomplishment of this. With the idea before us that the practitioner is to treat his cases without special preparation, because he does not see them often, the best method is that by ligature.

Its advantages are that it is certain, and, if properly performed, safe; its disadvantages are mainly two. Sometimes, but not always, more or less distress, sometimes great pain even, is felt for a few days, and after this operation a patient is confined to bed some days.

The only instruments necessary are a pair of scissors and a strong ligature. The improved method of Allingham is the one to employ. This contemplates the partial dissection of the base of the tumor towards the vessels which enter it from above. The operation should be done under an anæsthetic, with the sphincter stretched. The ligature is tied in the groove made by dissection around the pedicle thus formed and cut short. It comes away in about a week, and at the end of a second week the patient is usually at liberty. But, before deciding upon this latter point, personally examine the former sites of the tumors. All patients do not get well rapidly; their cicatrizing power is feeble.

If the cases seen by the practitioner are sufficiently numerous to justify him in providing himself with the necessary instruments, he will find the clamp and cautery method of treatment an ideal one, and it has not been intended to prefer the ligature to it without some qualification of the statement of preference. While not so simple of performance, it is followed by less distress, and recovery is usually more speedy after it than after the ligature. The surgeon who permits his patients to walk out on the fourth day, however, as has been reported, does not decide for their best interest. A week or ten days should elapse, unless an examination shows the wounds healed. If resorted to, two or three precautions are best heeded. Do not use it on tumors high up in the rectum. Open the clamp slowly, and if there is any tendency to bleed, screw up the clamp and again apply the cautery. The cautery is sufficiently hot when dull red, and the part of the stump to which particular attention should be paid in applying the cautery is that farthest from the operator—i. e., where the vessels enter.

Before either operation see that the bow-

els are thoroughly emptied, and after it introduce an optimum suppository.

There are one or two other methods advised, but they are not all that could be desired. One of them, called after the name of an eminent English surgeon, consisting in excision of the "whole of the pile-producing areas," deserves to be forgotten, not because it is not simple, but because it is not safe.

A form of hemorrhoidal disease characterized by sessile granulations which bleed easily is best treated by the very old method of applying nitric acid. Introduce a speculum, dry the parts with gauze, and touch the whole granular surface again and again with a bit of cotton moistened with the acid, but containing so little that it will not run over the parts not diseased.

Lastly, before beginning any treatment, look out for complications. Especially in women should the pelvic organs other than the rectum be examined. In children examine the urinary organs.

Sterility and Its Cause.

Abstract from an article on "Ovarian and Tubal Diseases in the Causation of Sterility," by Thomas A. Ashby, M.D., in the American Journal of Obstetrics.

It has been customary to deal with sterility as dependent upon mechanical and inflammatory conditions located in the uterus. This organ has received unlimited attention, and, I may say, has been punished with many forms of procedure for the correction of its abnormal states, upon the assumption that sterility was dependent upon contraction or curvature of the uterine canal or upon conditions of the endometrium, which prevented conception and gestation.

Whilst clinical experience has shown the large influence which uterine disease has exercised in the causation of sterility, experience is accumulating to show that attention should be directed to a more careful study of the influence of the tube and ovary in the causation of the sterile condition. The functions of the tube and ovary in the reproductive act are too well known to be

stated in this connection. Both of these organs are subject to abnormalities of development, to alterations of position, and to structural changes dependent upon inflammatory and morbid action which may impair or completely destroy function. Under normal conditions in woman the relations of the tube and ovary are most delicate, and the adjustment of one to the other is brought about by movements which frequently operate with uncertainty. The fimbriae surrounding the outer end of the pavilion of tube, like a collar with many fringes, do not seem to offer the most perfect mechanical arrangement for the grasp of the ovum, or for its reception when cast out of the follicle. The exact manner in which adjustment takes place has not been worked out with sufficient accuracy to determine whether the tube grasps the follicle or whether the ovum is washed down into the pavilion. It is held by one set of authorities that the application of the pavilion is brought about either by the contraction of the muscular fibres it contains or through the distension of the bulb of the ovary. When this mechanism is insufficient the ovum falls into the abdominal cavity. Many ova are undoubtedly lost in this manner. Henle has suggested that the passage of the ovum into the tube is due to currents produced in the serum by the ciliated epithelium which covers the surfaces of the fimbriae. Some strength is given to this theory from the fact that one of the fimbriae is permanently attached to the lower angle of the ovary, which would seem to favor the floating down of the ovum into the pavilion of the tube. The migration of the ovum into the tube undoubtedly occurs under remarkable mechanical conditions. The experiment of Leopold in which the tube on one side was ligated and exsected and the ovary on the other side removed in the case of a rabbit, followed by subsequent impregnation, proves the wide application of mechanical conditions in favoring the function of reproduction.

Whilst it is probable that the mechanical conditions which accompany the reproductive function in woman are seldom disturbed

when nature has not gone astray by disease or accident, yet we cannot observe the very delicate and intricate arrangement which provides for the grasp of the ovum as it escapes from the ovary without realizing that trivial conditions may be sufficient to defeat the purpose and result in loss of the ovum. That many such losses occur even in health there is every probability. When there is added to these delicate movements the restraining influence of accident and disease, the occurrence of proper adjustment becomes more and more remote in proportion to the nature and extent of such restraints.

In addition to the structural changes observed in connection with the tube, the ovary may play no insignificant part in defeating the act of reproduction. This organ may be at fault structurally, as well as in its position in the pelvis and in its relation to the tubes and uterus. Change of position, whether transient or permanent, might offer such obstacles to coaptation with the ostium of the tube as to result in the loss of the ovum and consequent sterility.

The Abortive Treatment of Gonorrhœa.

Pest. Chirurg. Presse.

In thirteen cases of incipient gonorrhœa, with only slight sero-mucous secretion, Dr. Feleki was able to effect a cure on the average in nine days by the following treatment: After the patient has urinated, an endoscope of as large a calibre as possible is introduced into the urethra somewhat beyond the limits of the affected mucous membrane, and then the parts are brushed by means of a cotton swab with a five per cent. solution of silver nitrate, care being taken that the solution gets between the folds of mucous membrane. The application must be made under guidance of the eyes. The pains produced are slight and do not last more than ten to fifteen minutes, so that previous cocainization is not necessary. The immediate effects of the procedure are pain in urination for one or two days, then diminution of the secretion, which does not

usually become purulent, and subsidence of the inflammation. Salol is prescribed internally, but injections are rarely resorted to. If the secretion is scanty one application is sufficient; otherwise it is repeated after two or three days in a milder manner. In but two cases was a third application requisite. The gonococci usually present at the initiation of treatment generally disappeared a few days after the application. This treatment, however, should be employed only in cases characterized by slight inflammatory appearances.

Proper Time to Give Alkalies, Etc.

Medical Summary.

Alkalies should be given before food. Iodine and iodides should be given on an empty stomach, when they rapidly diffuse into the blood. If given during digestion the acids and starch alter and weaken their action. Acids, as a rule, should be given between the digestive acts, because the mucous membrane of the stomach is in a favorable condition for the diffusion of acid into the blood. Acids may be given before food when prescribed to check the excessive formation of the acids of the gastric juice. By giving it before meals you check the osmosis stomach-ward of the acid-forming materials. Irritating and dangerous drugs should be given directly after food, such as salts of arsenic, copper, zinc and iron, except where local conditions require their administration in small doses before food. Oxide and nitrate of silver should be given after the progress of digestion has ended; if given during food, chemical reactions destroy or impair their special attributes, and defeat the object for which they were prescribed. Metallic salts, especially corrosive sublimate, also tannin and pure alcohol, impair the digestive power of the active principle of the gastric juice, so should appear in the stomach during its period of inactivity. Malt extracts, cod-liver oil, phosphates, etc., should be given with or directly after food, so that they enter the blood with the products of digestion.